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ABSTRACT

This paper reports on efforts underway in New York State to develop the Individualized Needs for Services Assessment (INSA). The INSA is a set of standardized procedures and data definitions to guide assessment of service needs for children with serious emotional disturbances (SED). The INSA procedure for children with SED is designed to be consistent with principles from the federal Child and Adolescent Service System Program, individualized service planning, applied data standards, and a logic structure adapted from the Medical Research Council Needs for Care Assessment. Service needs are assessed using interdisciplinary teams with the participation of family members. Representatives from child welfare, juvenile justice, alcohol substance abuse, primary health care, recreation, and other relevant programs or community organizations also may be included. Functioning is assessed for the following domains: self-care; family life; social and interpersonal relationships; learning; school performance; vocational relationships; disruptive behavior; mood symptoms; anxiety symptoms; symptoms of psychosis; attention deficit and/or hyperactivity symptoms; and alcohol and/or other substance abuse. The child's functioning in each domain is rated according to a four-point scale from no problem to severe. (Contains 13 references.) (CR)

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The Individualized Needs for Service Assessment (INSA) for Children with Serious Emotional Disturbances

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Background & Significance

This summary reports on efforts underway in New York State to develop the Individualized Needs for Services Assessment (INSA), a set of standardized procedures and data definitions to guide assessment of service needs for children with serious emotional disturbances (SED). The INSA is intended to be used by: (a) service providers and family members who want to develop individualized service plans; (b) planners and policy makers who want to quantify need for services at the community level, and services researchers who want to study factors correlated with service needs; and (c) managed care organizations and purchasers of services who want to balance issues of ensuring access to needed services while reducing provision of unnecessary, ineffective, or overpriced services.

A major challenge confronting the mental health field is to operationalize and quantify the concepts of need and unmet need for services (Klerman, Olfson, Leon, & Weissman, 1992; Bebbington, 1990). Policymakers, service providers, and advocates for children with emotional disturbances consistently place a high priority on the provision of sufficient services to meet what are perceived to be high unmet needs for services. Methods for detecting and diagnosing emotional disorders in children have improved and become more standardized. However, there are no standardized procedures either for determining which services are needed in individual cases or for specifying the community service capacities needed to serve diagnostically defined subpopulations.

Assessment of service needs is complicated by the fact that children with SED frequently are served by multiple provider systems. Needs typically have been defined in terms of organizational settings or program components, such as residential treatment facilities, clinics, or day

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treatment programs (Burns, Angold, & Costello, 1992; Pires, 1990). Yet, a program component approach does not clarify what service items are needed and makes it difficult to measure the extent to which service needs are met by other systems of care that may deliver similar services but use incompatible terminology. It also creates problems in applying findings from one geographic region to another, where services may be organized differently, or for designing new forms of service organization that would be more efficient in meeting needs.

Individualized Service Planning

The federal Child and Adolescent Service System Program (CASSP) initiative identified children with SED as a high priority, given that many of them are underserved and in need of advocacy, while others are treated, often ineffectively, in costly inpatient settings and other out-of-home placements (Stroul & Friedman, 1986). CASSP selected the following as basic parameters for defining the population of children with SED: (a) impaired social functioning in family, school, and neighborhood contexts; (b) in need of a range of services requiring the involvement of multiple agencies including the mental health, health, education, child welfare, juvenile justice sectors, and others; and (c) impairment that has lasted or is expected to last one year or more. CASSP envisioned a child-centered, community-based system, providing a comprehensive array of services including mental health, social, educational, health, vocational, recreational, and operational components (Stroul & Friedman, 1986).

Recent literature has placed emphasis on principles that lay a foundation for services that are (a) flexible and accommodate the individual needs of the child and family, (b) family-focused and involve the family in planning, and (c) competent and meet the needs of multi-cultural populations (Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy, Lourie, Stroul, & Zeigler-Dendy, 1992). CASSP envisions the development of individualized service plans as a critical aspect of practice within a comprehensive system of care and that should have a strong bearing on what services a child and family ultimately receive (Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; Duchnowski & Kutash, 1993; Katz-Leavy et al., 1992; Rivard, Perry, & Hinkle, 1994). With the growing programmatic emphasis on individualized service approaches &emdash; based on the principles of unconditional care, family involvement, multi-cultural competence, delivery in a child's natural environment, and tailoring to the individual needs of the child and family &emdash; knowledge about appropriate assessment of individual service needs is sorely needed.

The growing emphasis on managed care to control access to and coordinate services places additional importance on the development of a consensus within the child mental health

field of what constitutes service need. Under traditional financing arrangements and multiple, uncoordinated delivery systems, there was little incentive to reduce costly or inappropriate provision of services for children who had access. The broad coverage and capitation financing arrangements envisioned under managed care will provide strong incentives to limit or deny care when services are judged as unnecessary. In the absence of guidelines for what constitutes need, the impact of managed care on children with SED may place children at even greater risk for under-provision of services.

MRC Needs for Care Assessment Approach

While the Medical Research Council (MRC) Needs for Care Assessment Procedure was developed for adults with psychiatric disabilities (Brewin, Wing, Mangen, Brugha, & MacCarthy, 1987; Mangen & Brewin, 1991; Brewin, 1992), it provides concepts, procedures, and a logic structure that we have adapted for assessing the service needs of children with SED. Needs are defined according to an assessment of functioning that includes domains related to psychiatric symptoms and social role performance. Generic service items (defined independent of program components) are listed under each functional domain where they are considered likely to be effective.

For any particular individual, need is defined according to assessment of functioning, the effectiveness that a particular service item is expected to have for this particular individual, and the acceptability of the service item to the individual. The procedure includes a logic structure that leads from judgments in these three areas to categories of need for each domain and each service item. In addition to results ranging from unmet need, partially met need, and met need, the procedure allows for ratings of no meetable need (i.e., when no interventions are judged to be effective and acceptable to address a domain problem for a particular individual) and overprovision (i.e., when the frequency or intensity of a service item exceeds what is required to achieve functional outcomes).

Process

The INSA procedure for children with SED is designed to be consistent with principles from CASSP and individualized service planning and applies data standards and a logic structure adapted from the MRC Needs for Care Assessment. The INSA is being further specified and tested in The SED Study, an National Institute of Mental Health (NIMH)-funded child mental health services research study being conducted by Columbia University (Christina Hoven, Principal Investigator) in Westchester County as well as in The FRIENDS Project, a Center for Mental Health Services (CMHS)-funded comprehensive services demonstration in the Mott Haven section of the Bronx.

Interdisciplinary Teams with Family Participation

In both settings, service needs are being assessed using interdisciplinary teams with the participation of family members. In Mott Haven, for example, once a child is found eligible for FRIENDS (based on criteria for SED), a team is assembled to develop an individualized service plan. Team members include parents or surrogate parents, the child (as appropriate), and representatives from the mental health and education systems. Representatives from child welfare, juvenile justice, alcohol substance abuse, primary health care, recreation, and other relevant programs or community organizations also may be included. Information about providers previously or currently serving the family or expected to serve the family in the future is considered in selecting team members.

The team reviews the thorough clinical and functional assessment conducted as part of the FRIENDS admission process, along with historical records, and gathers any additional information required for the needs assessment. Team members complete INSA forms individually, and then the team discusses each component of the assessment with the goal of achieving consensus on all phases. The team's INSA results represent what the child needs ideally. This information is then used by the team to develop an individualized service plan that factors in how services can best be delivered given real-world constraints of availability, organization, and financing of existing services. Analyses comparing INSA results with individualized service plans will be conducted to support community planning and funding allocation. For the Westchester study, a similar process is being undertaken, incorporating an expert, multi-disciplinary panel into the research process.

Data Standards and Logic Structure

Functional Domains

Functioning is assessed for the following domains: (1) self-care; (2) family life; (3) social and interpersonal relationships; (4) learning, school performance, vocational

relationships; (4) learning, school performance, vocational development; (5) disruptive behavior; (6) mood symptoms; (7) anxiety symptoms; (8) symptoms of psychosis; (9) attention deficit and/or hyperactivity symptoms; and (10) alcohol and/or other substance abuse. The child's functioning in each domain is rated according to a four-point scale from no problem to severe. Additional instrumentation is in development to support functional ratings responsive to the child's developmental stage.

Service Items

The INSA approach incorporates a taxonomy of over 75 generic service items thought to be capable of meeting need. "Generic" refers to service items that are generalizable and comprehensible across different organizational units and systems of care. Examples include:

- psychotherapy, brief or short-term individual, for the child;
- home-based training in parenting skills, child behavior, and symptom management for parent(s) or family members; and
- peer support, self-help, or support group for the child.

For each functional domain, service items thought likely to be effective according to expert judges are listed. Some service items appear under multiple domains. For those functional domains where the child is experiencing problems, team members rate service provision according to a scale that takes into account both current and past receipt of the service item.

Anticipated Clinical Effectiveness

The team rates the anticipated clinical effectiveness of each service item in addressing problems the child is experiencing in a given domain according to the following scale: (0) demonstrated ineffective with adequate trial; (1) no adequate trial, but judged to be ineffective; (2) no adequate trial, but believed to be effective or partly effective; (3) partly effective based on adequate trial; (4) demonstrated effective based on adequate trial; (8) inconclusive, judgment deferred; (9) not applicable. These judgments incorporate knowledge found in the professional literature (e.g., outcome studies, practice guidelines) as well as factors specific to the individual, such as service history.

Child and Family Acceptability of Services

The team rates the level of acceptability of the service item to the child and family according to the following scale: (0) rejection; (1) not likely to be acceptable; (2) likely to be acceptable; (3) demonstrated to be acceptable; (8) uncertain; (9) not applicable. This rating is made considering the family's prior experience with similar approaches, cultural appropriateness, and other factors related to individual preferences.

Need Status

Need status is measured according to the following scale: (0) no need, (1) no meetable need; (2) unmet need for assessment/trial; (3) unmet need for provision; (4) met need, maintain current frequency/intensity; (5) met need, increase frequency/intensity; (6) met need, assess overprovision. In addition, a judgment as to the presence or absence of overprovision is made when indicated. A logic structure that considers the ratings made on the above dimensions either determines the rating on need status or narrows the response categories available for any given rating. For example, a service item with an acceptability rating of rejection or a clinical effectiveness rating of ineffective would lead to a need status of no meetable need. A computerized version of the needs assessment, that automates the logic structure, is being planned.

Discussion

The INSA approach offers a standardized set of methods for assessing the service needs of children with SED that may be applied to individualized treatment planning, managed care, services research, and community planning. When aggregated across individuals, need may be studied on at least three levels: (1) global measures of need and unmet need, such as whether any unmet need is present or the number of items with unmet need; (2) functional domains, such as what factors are associated with unmet need for services designed to address disruptive behavior; and (3) individual service items, such as factors associated with need for behavior therapies. Over time, the INSA will be adapted to incorporate new knowledge about service strategies and effectiveness.

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